



CERTIFICATION OF ENROLLMENT

Youth for Adolescent Pregnancy Prevention Program/Leadership Recognition Program

- THIS SECTION IS TO BE FILLED OUT BY THE STUDENT -

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

SOCIAL SECURITY NUMBER: _____

SCHOOL NAME: _____ PROGRAM: _____

☐ FALL ☐ WINTER ☐ SPRING YEAR: _____ ☐ SEMESTER ☐ QUARTER

DATE SEMESTER/QUARTER BEGAN: _____ DATE SEMESTER/QUARTER ENDED: _____

CUMULATIVE GPA: _____

PLEASE NOTE THAT THE SOONER THIS FORM IS RETURNED TO THE FOUNDATION, THE SOONER YOUR SCHOLARSHIP CHECKS CAN BE PROCESSED.

- THIS SECTION IS TO BE FILLED OUT BY THE DEPARTMENT DEAN OR APPROPRIATE DESIGNEE -

The student named above has been awarded a scholarship from the Health Professions Education Foundation. The student may continue to receive scholarship funding only while he or she is pursuing a course of study leading to a health professional degree. This form must be completed and returned in order to receive scholarship funding.

This form must be completed by the health professions education program director. However, if the student is currently completing prerequisite or general education coursework and is not currently enrolled in a specific health profession program at this time, this form must be completed by one of the following individuals: **1) Department Dean, 2) Academic Advisor, 3) Educational Counselor, 4) Financial Aid Advisor, or 5) Scholarship Officer.**

Please check all that apply:

- ☐ I certify that the foregoing information is true and correct to the best of my knowledge.
- ☐ I certify that I am the Program Director.
- ☐ I certify that I am authorized to sign this document on behalf of the Program Director.

Print Name

Signature

Title

Date

Phone Number

Attach Business Card Here